AUXILIARY COMMUNICATIONS SERVICE
GOVERNOR'S OFFICE OF EMERGENCY SERVICES

EMERGENCY NOTIFICATION AND MEDICAL HISTORY

Name _____**Date of birth:**_____

Address _____City_____Zip_____

A: IN EVENT OF ACCIDENT OR INJURY, NOTIFY THE FOLLOWING:

1st choice: Name _____Relationship_____

Address _____City_____Zip_____

Telephone: Home _____ Work_____

2nd choice: Name _____Relationship_____

Address _____City_____Zip_____

Telephone: Home _____ Work_____

B. IN EVENT OF DEATH, NOTIFY THE FOLLOWING IN ADDITION TO THE ABOVE:

Additional: Name _____Relationship_____

Address _____City_____Zip_____

Phone numbers: Home _____ Work_____

C: MEDICAL AND PHYSICAL HISTORY

Blood Type_____ **HMO**_____ **HMO ID #**_____**Doctor:** _____

Medications currently taking_____

Medications to which you are allergic _____

Conditions a physician or hospital may need to know (diabetes, epilepsy, heart, kidney, implant, etc.)

_____

_____

History of illnesses, injuries operations:_____

_____

_____

Physical limitations_____

_____

_____

_____